

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH.

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-045313

DO NOT WRITE  
ON THIS STUD

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

11139

STATE FILE NUMBER

VS 300  
Rev. 4/59

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USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO.

SHOULD READ

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		d. STREET ADDRESS (If outside, give location) <b>5906 Cote Brillante</b>	
3. NAME OF DECEASED (Type or print) First <b>Macon</b> Middle <b>Chunn</b> Last		4. DATE OF DEATH Month <b>11</b> Day <b>7</b> Year <b>63</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-17-1904</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		11. BIRTHPLACE (City and state or country) <b>Ala.</b>	
13a. FATHER'S NAME <b>Warren Chunn</b>		13b. MOTHER'S MAIDEN NAME <b>Mattie Hall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		17. INFORMANT <b>Mary Chunn</b>	
16. SOCIAL SECURITY NO. <b>[REDACTED]</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO (b) <b>Carcinoma of Left Lung</b> DUE TO (c) <b>163X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>8-15-63</b> to <b>11-7-63</b> and last saw him alive on <b>11-7-63</b>		22a. SIGNATURE (Degree or title) <b>[Signature]</b>	
22b. ADDRESS <b>2601 N. Whittier</b>		22c. DATE SIGNED <b>11-8-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>11-13-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, County Mo.</b>
24. FUNERAL DIRECTOR <b>Harris-Boyd Mortuary</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 12 1963</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>

(Licensed Embalmer's Statement on Reverse Side)

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

*Henry Williams*

Licensed Embalmer No. 4781

P. O. Address 8706 Kinney

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.